Psychiatric care in prepayment medical plans is a topic of considerable current interest. Here is a report on the experience of one plan where psychiatrists have been involved for over a decade in prepaid group practice.

THE ROLE OF THE PSYCHIATRIST IN A PREPAID GROUP MEDICAL PROGRAM

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THE ST. LOUIS Labor Health Institute (LHI) provides medical care through a voluntary prepaid medical plan serving more than 15,000 eligible members. Within a year after its organization in 1945, a psychiatrist was employed on an experimental basis, initially for a two-hour period each week. There was no established precedent for his function, necessitating a trial and error adaptation to the demands put on him, adjustment to the resistance of patients and staff members alike, and accommodation to the economic realities of the institute and the limitations imposed upon the medical program by financial factors. Since the aim of the LHI is to provide an integrated program of medical care on a group practice basis, it was necessary for him to become a member of the medical team.

Approximately 50 physicians and dentists are employed part time on salary. Most patients are seen at the medical center. Hospital care is also provided, in addition to visits at the patient's home. The LHI operates its own hospitalization plan with benefits somewhat more liberal than those offered by Blue Cross. For example, psychiatric patients receive one month's hospitalization in contrast to the Blue Cross' two weeks. All medical and surgical specialties are covered, either by regular staff members, or by outside consultants who are paid on a fee-for-service basis. Medical facilities are divided into sections, each directed by a chief of section.

Currently, three psychiatrists provide 20 hours a week to the neuropsychiatric section. They examine and treat all patients, generally referred by other physicians, although some are self-referred, who have neurologic or psychiatric problems. Patients are also treated in the hospital; most of these have neurologic disorders. Approximately 20 per cent of all patients referred to the neuropsychiatric section are neurological cases.

There are 6,244 union members, who, with their families, comprise the 15,036 persons entitled to LHI care in 1958. Approximately 9,000 of these avail themselves of services in any given year. During 1957, 1,805 new patients were seen in the center. Total visits numbered 102,823. In the same year 486 patients consulted the neuropsychiatric section, 120 patients for the first time. There were a total of 1,297 visits. Since all are members of Local 688 of the Teamsters Union, they represent a relatively homogeneous socioeconomic group, primarily semiskilled workers in ware-

housing or light manufacturing plants, with an average weekly wage of $60-$90. Because of financial limitations, such people generally cannot afford private psychiatric care. We were interested in the incidence of emotional disorders in this group of working people; although our figure of 6.6 per cent seems to be low because the demand for psychiatric care is slightly more than half met, it represents a base line. A 10 per cent incidence would probably be a more accurate level.

Program of Psychiatric Service

The psychiatrist acts as consultant to the medical staff and as therapist to individual patients requiring treatment. As consultant, the psychiatrist returns half of the patients referred for diagnostic appraisal back to the referring physician for continued care. Evaluation of the patient's personality and symptoms becomes an important factor in the future course of the medical care of certain patients. For example, prior to hospitalization, the case history of each patient is reviewed by the entire medical staff at weekly meetings. The judgment of the psychiatrist becomes an important factor in the decision to perform some operations, or whether the patient is even hospitalized.

The treatment program is geared to the medical needs of the patient, but is kept within the economic framework of the LHI. Actually, psychiatric practice at the LHI is probably very similar in character to the private practice of many psychiatrists, but it is much different from the private practice of a psychiatrist who primarily engages in intensive long- or short-term psychotherapy. Because of the close association with other specialties, many patients are referred to the psychiatrist who usually would be carried by the internist or the general practitioner. Because of the severe time limitations for appointments, for maximum efficiency, the length of appointments must be carefully budgeted and scheduled according to the type of case. Since only 25 or 30 minutes are available on the average, time is used most effectively when a chronic supportive case, or a nonmoving case, preoccupied with somatic symptoms, is given an appointment of only 10 to 20 minutes, while a person with a good many personality assets is allotted 40 or 45 minutes.

Most psychiatric patients do not absent themselves from work while attending the medical center. Very few are hospitalized, except for diagnostic study, or in severely disturbed states. Where feasible, electroshock therapy has been given on an outpatient basis at the hospital. Treatment has been classified as (1) supportive, (2) suppressive, (3) dynamic psychotherapy.

Supportive Therapy—Frequently it is possible in one, or two, or at most very few interviews to explore with the patient on a quite superficial level the meaning of his presenting disturbances. It seems wise in these cases to go no further, and by reassurance and simple interpretation, to relieve distress and anxieties. In this way the psychiatrist serves as an adjunct to the medical or surgical department, helping to clear up threatening and disturbing symptoms. For example, following an operation for removal of a herniated disc, the persisting pain confined the patient to bed for several weeks, and subsequently she required re-hospitalization. The psychiatrist recognized this patient's persistent illness as a reaction to her quarrel with a daughter over the former's paramour. The illness served as a bid to enlist the daughter's interest and friendship. She was isolated in her home. Two weeks in a convalescent hospital, where she received psychotherapy, engaged in occupational therapy, and was surrounded by friendly hospital staff and fellow patients, provided emotional support. In addi-

tion, during three psychiatric interviews, she was able to "ventilate" and gain an appreciation of the emotional aspect of her symptoms, which promptly cleared up and she was able to resume work. No further therapy appeared necessary at this point.

Suppressive Therapy — In instances where interpersonal relationships at home or at work are more seriously disturbed, amelioration of symptoms, rather than resolution of conflicts may become the aim of treatment. Use of sedatives, inhalations of carbon dioxide, and even electroconvulsive therapy seem indicated and are utilized. Some support is additionally provided in interviews. For example, a case of ulcerative colitis could not accept psychotherapy. Use of carbon dioxide was promptly followed by an arrest of symptoms, and x-ray findings, which had progressed for two years previously, showed marked resolution of the pathological process. There was a decrease of bowel movements to one a day, and a gain in weight. In other instances, depressed patients could be restored to work within two or three weeks. It is frequently necessary to make interpretations to members of the family, and more particularly, to the personnel director as to the significance of the patient's symptoms and behaviors. Such "environmental manipulations" help tremendously in the treatment program.

Dynamic Psychotherapy—More intensive psychotherapy is limited to a relatively small number of patients, consistent with the time available to the psychiatrist. It is practically impossible to give a patient more than one appointment a week no matter how great the need. Nevertheless, it is possible to treat successfully over a period of several years, such long-term complex cases as homosexuality, gifted personalities with psychotic potential, some severe personality disorders, some fairly severe neurotic disturbances. This is regarded as an effective approach to a group of patients who otherwise could rarely have the help of a psychiatrist. The relationships with these patients develop similarly to those in a private psychiatric setting.

Results of Treatment

Details of randomly selected case histories of 471 neuropsychiatric patients treated during a period of eight years are analyzed. Ninety-six were neurological problems, 369 were psychiatric cases, and six were found to be free of neuropsychiatric disorders; 36 children were included in the group. Of the psychiatric cases, 320 were nonpsychotic, 49 were psychotic. The latter group included seven manic-depressive reactions, 35 schizophrenic reactions, 14 of whom might have been included as a group of hypochondriasis with fixed systematized symptom reactions.

The nonpsychotic patients were classified in accordance with the American Psychiatric Association nomenclature with the following major groups:

1. Psychoneurotic reactions, 181 cases. These included anxiety, depressive, obsessive-compulsive, phobic and conversion reactions.
2. Psychophysiological reactions (psychosomatic), 89 cases.
3. Personality disorders, 50 cases (Table 1).

An attempt was made to correlate the number of visits to the psychiatric clinic with the change in symptom status of the patient. It is admittedly difficult to evaluate improvement in such patients, since frames of reference vary widely. Using the criterion of relative well-being, and the ability to function in the patient's appointed job, each psychiatrist recorded his own impressions. Our data show that 40 per cent of the patients made one or two visits. This group is recorded as showing a 20 per cent improvement rate, in contrast to the 75 per cent improvement rate in the group making three or more visits. There was an

Table 1—Incidence of Psychiatric and Neurological Cases, Showing Numbers of Improved and Unimproved

Nonpsychotic Cases			
Psychoneurotic Reactions	Number	Improved	Unimproved
Anxiety Reactions	86	46	40
Depression Reactions	38	24	14
Obsessive-compulsive reactions	5	1	4
Phobic reactions	19	11	8
Conversion reactions	33	10	23
Totals	181	92	89
Psychophysiological Reactions			
Musculoskeletal reactions	36	21	15
Cardiovascular reactions	18	8	10
Skin reactions	8	5	3
Gastrointestinal reactions	18	13	5
Others	9	5	4
Totals	89	52	37
Personality Disorders			
Totals	50	26	24
Total Nonpsychotic Cases	320	170	150
Total Psychotic Cases	49	16	33
Total Neurological Cases	96		
Consultations—No neuropsychiatric disease	6		
Grand Total—Cases	471		

over-all improvement rate of 53 per cent. The great majority of patients made no more than ten visits to the psychiatrist. The group with psychosomatic disorders had the best rate of improvement, even within the "fewest visits" bracket. The inference drawn here is that this group of disorders lends itself best to brief superficial therapy in a medical context such as exists at the LHI. It is also apparent that from three to ten visits for patients referred to the psychiatric clinic is the most fruitful and economically feasible program for the center.

There is a great opportunity in this type of practice for close association with men in other medical specialties, with a close interchange of ideas and collaboration in treating patients. Both the psychiatrists and the other specialists can benefit from this interchange of ideas and approaches in medical therapy. One direct result of this close collaboration is reflected in the frequency with which other physicians turn to the psychiatrist for advice and help. This contrasts with the negative attitude manifested by some physicians in the very early days of the group which so often reflected itself in the resistance of patients who were referred for consultation.

Administrative Problems

Although there are serious inadequacies in the program, it must be remembered that LHI is perhaps unique in the kind of comprehensive psychiatric care provided for its members. The extent of such care is naturally limited by the budget. Immediate demands for

services of other specialties must be weighed against requirements for augmenting the psychiatric services. A social worker would be a great asset to the team. In the early years of the program one was indeed employed, but proved unsatisfactory personally because of her inadaptability to the peculiar needs of a prepaid group program. Increased staff hours are needed, and will be provided as soon as the budget permits. The lack of both a social worker, and of more staff hours is particularly compromising for the field of child psychiatry, making it almost impossible to treat children adequately in such a setting. The need for a worker to see the child, another worker to see at least one parent, makes even greater demands upon the very limited facilities of the group. Part of this difficulty is overcome by employing a psychologist periodically on a fee basis to meet this need, and for clinical testing. It would be preferable to add the psychologist to the regular staff for continuing service. By and large, it has become necessary to refer children requiring much treatment to a community child guidance clinic. Utilization of other community resources, such as a speech training center, occupational therapy workshops, and consultations with personnel directors of the various employing firms, have been exceedingly helpful. Plans for group therapy have been considered, but so far have not been executed.

Industrial Psychiatry Aspects

Certain problems are common to industrial medicine in any setting, such as sick leave, compensation claims, reemployment and the like. These frequently arise in this setting and the LHI physicians inevitably and unwittingly become involved with them. The physician's distaste for this facet of medical practice is exemplified by the reluctance to treat any compensation cases that may present themselves, though service is not refused to patients who ask for it. The LHI physician is even more loathe to become entangled in a dispute between patient and employer, whether it concerns certification for sick leave to which each patient is entitled upon his visit to the medical center, the employer's concern about excessive absenteeism, or the patient's striving to secure his job again after a disabling illness. Despite his own feelings, the thoughtful and conscientious physician is soon faced with a need to understand the meaning of these situations in his therapeutic relations with the patient. In this manner, the neuropsychiatric section has approached the problem of industrial psychiatry from the employee's point of view. At this time wo do not wish to enlarge upon this subject other than to comment that it is rare for patients to bring direct complaints about work to the psychiatrist. Rather, some of the presenting symptoms and medical demands made by the patient, e.g., demands for prolonged sick leave, and so forth, are subtle manifestations of their resentments, and could be explored if this is desired.

Mental Hygiene Program

It would seem that the preventive medicine approach of the LHI would provide support from the administration, medical personnel, and membership of the group for a program of mental hygiene. At various times, attempts have been made to institute a program of education for patients, dealing not only with mental health, but also with other aspects of health. Posters in the waiting room advertise health habits and procedures, e.g., weight reduction, adequate diet, polio vaccination, periodic physical examinations. A series of lectures to groups of about 20 patients was instituted, covering such subjects as infant care, obesity, and heart disease. The psychiatrist participated in these talks

presenting the emotional aspects of these problems, and a health educator was appointed to direct the entire program. Movies illustrating some of the subjects were shown to patients assembled in the waiting rooom. On the whole the program was sound, but unfortunately was discontinued after one year, primarily because of lack of personnel and funds to support it. It is our belief that this program should be reactivated, since the patients manifested much interest in it.

Opportunities for Research

Reference has already been made to the industrial psychiatry aspect of the program. Attempts have been made to explore with personnel directors some of the mutual problems facing employers and psychiatrists. A series of meetings were held to this end in which discussions were freely developed between representatives of the employers, the LHI, a psychiatrist, and a psychologist. Questions of absenteeism, sick leave, reassignment of recovered patients, and employment of epileptics were discussed. Naturally, in such a mixed group, heated arguments arose which were not easily resolved because of conflicting interests. That such meetings could have taken place at all is an encouraging sign, and it requires follow-up and analysis.

Data can be assembled over a number of years which would give a true index to the incidence of psychiatric disorders in a close knit socioeconomic group. Group therapy can be a real source of research data should such a program ever be instituted. Study in race relations is possible, inasmuch as at the LHI there is no color bar within the professional, administrative, or patient groups. Here is a real opportunity for exploration of the needs, feelings, and attitudes of Negro patients not usually present in other settings in the St. Louis area.

Summary and Conclusions

1. A psychiatric program within a prepaid voluntary medical program has been operating successfully since 1946, and has expanded its facilities. Further extension of this program, based on past experiences, is urgently needed.

2. Within this setting the psychiatrist has functioned as a member of a medical team, closely cooperating with other physicians, and with dentists in the care of the patient. This has afforded an opportunity for mutual education among the various doctors, and the development of insight into the emotional aspect of sickness.

3. An incidence of 6.6 per cent of emotional illness within the total patient load was established for the year of 1957. This undoubtedly underestimates the true incidence of psychiatric illness in this group of patients.

4. Psychiatric services have been made available to a socioeconomic group which ordinarily could not avail itself of such services in private practice.

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